

ADMISSION, DISCHARGE, AND TRANSFER (ADT)

This Care Coordination Tool training guide will focus on the Admission, Discharge, and Transfer (ADT) tab.

After this self-guided training, you should be able to perform the following functions:

- 1.1 Engage a Member in Care Transition
- 1.2 View Required Activities
 - View Required Activities by Event Type
 - Schedule Required Activities
- 1.3 Sort Members by Risk
- 1.4 Export ADT Information to Excel
- 1.5 Grouping Multiple ADT Records
- 1.6 Synchronizing ADT Status with the same Admit Date and Time
- 1.7 Exercise: Schedule an activity for a member who has been discharged from a hospital

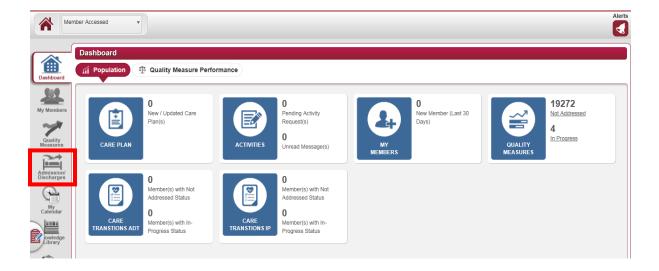
Appendix

1.8 Event Types



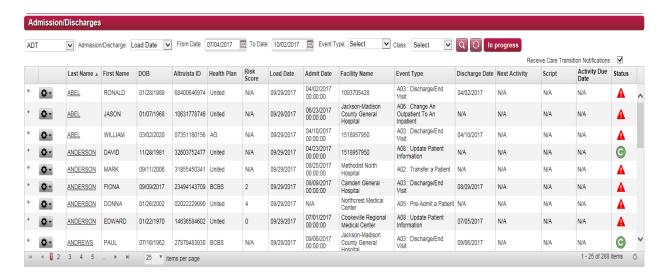
1.1 Engage a Member in Care Transition

When a provider logs into the Care Coordination Tool, the Dashboard appears as shown below:



1. Click the **Admission/Discharge** tab. The Admission/Discharge tab displays the members who have had ER admissions and discharges. The State is working with hospitals throughout Tennessee to encourage them to supply their ADT data to the Care Coordination Tool. Many hospitals have begun sending their ADT feeds, but please note that not every hospital's information will appear in the tool at this time.





Once a member has been admitted to the hospital, their provider should contact them and follow up. In the Care Coordination Tool, this follow up is known as a "Care Transition Program."

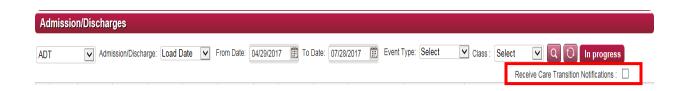
- The **Status** of members being engaged into Care Transition Programs appear as follows:
 - 📤 : Member is not engaged in a Care Transition Program
 - ! Member is engaged in Care Transition Program
 - : Member has completed the Care Transition Program



Select the **Receive Care Transition Notifications** check box seen at the top right corner of the page to enable receiving alerts and notifications to the registered email address of the provider. Once this option is selected, a



user will only receive email notifications when an assigned member has ADT data loaded into the Care Coordination Tool.



b. Select a Care Organization (or multi-select care organizations using the checkboxes), Program, OR Program Status from the drop-down lists. Note: Program and Program Status must be selected from the Additional Search Parameters options to be utilized. Alternatively, a user can select the search name from the Saved Search drop-down if the user would like to look for members with specific search parameters which were saved at an earlier time.



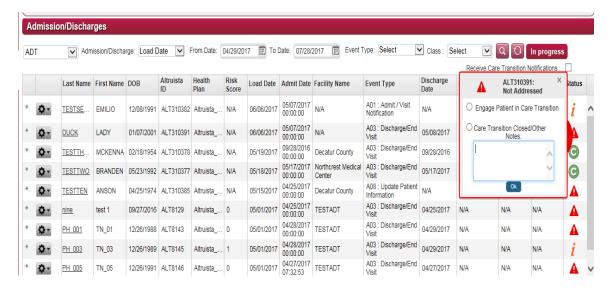
A user can also search for members by selecting the Admission/Discharge drop down, and entering a From Date, To Date, and Event Type.



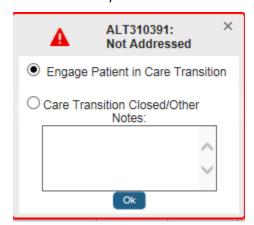
Note: The Event Type of A08 Update Patient Information does not require any action from providers and should therefore not be utilized. To search for a specific member, search with Member Name or Member ID, click Search, and search results will populate.



2. To engage a member into a Care Transition Program, click the red triangle under the Status column.



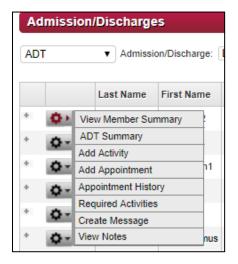
a. Select the option Engage Patient in Care Transition, enter notes if required, and click OK, or select Care Transition Closed/Other.



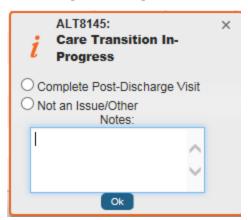
- i. If Engage Patient in Care Transition is selected, the status of the ADT record changes from Not Addressed to Care Transition In-Progress.
- ii. If Care Transition Closed/Other is selected, the status of the ADT record changes from Not Addressed to Completed.



Note: If you want to add an activity/appointment for the member, click on the cogwheel icon next to the last name column and select Add Activity/Add Appointment, **respectively**.



3. To complete a post-discharge visit, click an In Progress status under the Status column, select the option Complete Post Discharge Visit, and click OK.



- a. The ADT status will change from care transition In Progress 1 to Complete ...
- b. If **Not an Issue/Other** is selected, the status changes from care transition In Progress to Not Applicable .

1.2 View Required Activities



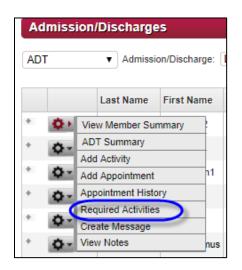
When a Member is engaged in a Care Transition Program, the program-specific required activities are displayed.

• View Required Activities for Event Type Ao1

Select the A01 from the Event Type drop-down list and click Search. Search
results are displayed.

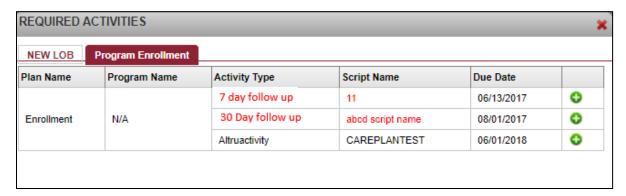


2. To view the Required Activities for a member, select Required Activities from the context menu by clicking on the cogwheel icon with the drop- down arrow next to the Last Name column.





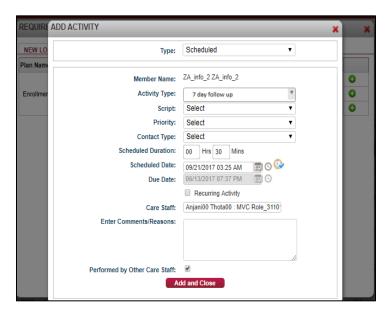
a. The Required Activities window will display Activities and Due Dates in the Program Enrollment tab. The icon on the right column will enable a user to perform the activity in the same row.



<u>Note</u>: Required Activities are pre-configured. Therefore when a member is engaged in a Care Transition program, the status changes from Not Addressed to Care Transition In Progress and the pre-configured Required Activities are displayed in the Required Activities section.

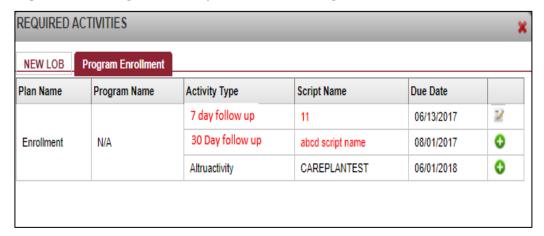
• Schedule Required Activities

- 1. Click **the ○** icon to schedule the activity.
- 2. The Add Activity window displays. Select the Scheduled Date, and click Add and Close.

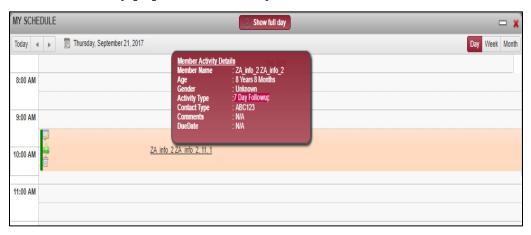




3. Upon scheduling the Activity, the **○** icon changes to **≥** as shown:



4. The scheduled activity **populates** in the **My Schedule** window:



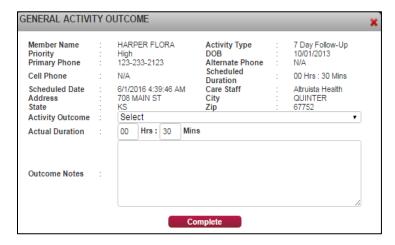
a. The Required Activity that must be performed next according to the Due Date is also displayed in the ADT tab under the Next Activity column. Examples of required activities include: Initial Contact (1 day post enrollment), 7 Day Follow Up (7 days post enrollment), and 30 Day Follow Up (30 days post enrollment).



b. You can click on the activity hyperlink displayed under Next Activity column so that the activity has been performed.



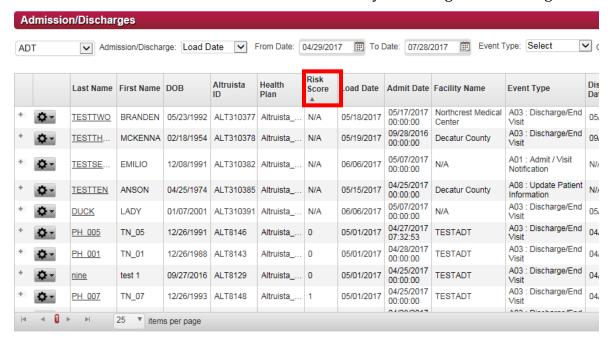
i. Clicking on the hyperlink displays the General Activity Outcome window (if the activity is a general activity).



- ii. Select the Activity Outcome, enter outcome notes, and click Complete to complete the activity.
- iii. The Next Activity column in the ADT tab is refreshed and the next configured required activity will be displayed in the column.

1.3 Sort Members by Risk Score in ADT Tab

1. Click on the Risk Score column to view members by ascending or descending order.



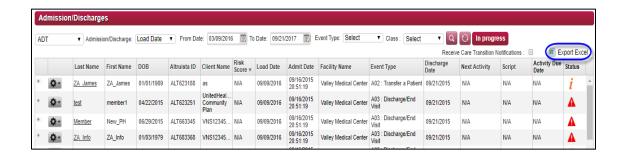


<u>Note</u>: The risk score numbers that appear in this column correlate to the risk categories of critical, high, medium-high, moderate, and low according to the following table:

Risk Category	ADT Risk Score Range
Low	0-0.5
Moderate	0.6-1
Medium High	1.1-1.8
High	1.9-3.2
Critical	3.3+

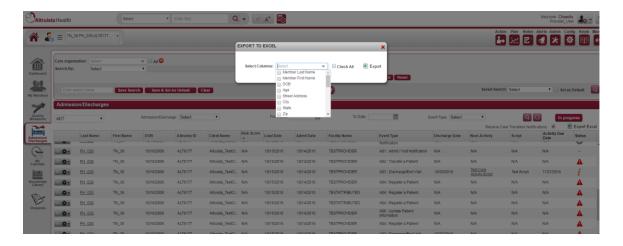
1.4 Export ADT Information to Excel

1. ADT data can be exported to Excel by clicking the Export Excel icon on the top right side of the ADT tab.



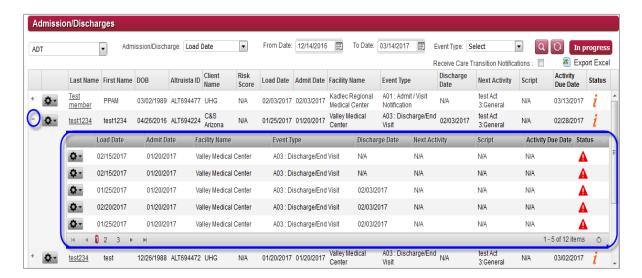
a. Specific columns can be selected using the drop-down list, or the Check All box can used to export all data into Excel.





1.5 Grouping Multiple ADT Records

Multiple ADT records for all members are grouped. Click the icon next to a member's last name to view the list of ADT records and their statuses with respect to each member as shown:



1.6 Synchronizing ADT Status with the same Admit Date and Time

If a member has the same Admit Date and Time for multiple ADT records, the status of the care transition program remains the same for all the records.

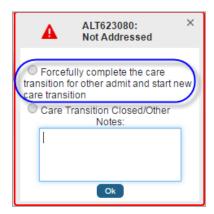




If a member's record is updated for the first time from the Not Addressed status to the In Progress status, the following options appear in the pop-up window:



If the Member has at least one ADT record in In Progress status, when you select 'Engage Patient in Care Transition' for a new record/new set of ADT records, a validation message appears stating 'Care transition for this member is in progress. Please select one of the below options to proceed.' and displaying the following options:





Selecting the 'Forcefully complete the care transition for other admit and start new care transition' option, will close the care transition for the ADT record (same date and time) which is in **In Progress** status and starts a new set of required activities for the current record.

When the ADT records are changed to a **Completed** status, the program enrollment will also end when the care transition is completed.

1.7 Exercise: Schedule an activity for a member who has been discharged from a hospital

- 1 Using the Event Type drop down list, select the **A03 Discharged** event type to filter by members who have been discharged from a hospital.
- 2 Using the cogwheel icon next to a member's last name, select **Required Activities**, then click on the **Program Enrollment** tab.
- 3 Click on the icon to schedule the activity that is due next.
- 4 Enter information about the activity in the **Add Activity** window and select **Add and Close**.
- 5 View the activity in the **Next Activity** column in the ADT tab. Also click on the **My**



Calendar Calendar

tab on the left side to view the activity on your schedule.



Appendix

1.8 Event Types

Event Type	Description
A01	An A01 event is intended to be used for "Admitted" patients only. An A01 event is sent as a result of a patient undergoing the admission process which assigns the patient to a bed.
A02	An A02 event is issued as a result of the patient changing his or her assigned location.
A03	An A03 event signals the end of a patient's stay in a healthcare facility. It signals that the patient's status has changed to "discharged" and that a discharge date has been recorded.
A04	An A04 event signals that the patient has arrived or checked in as a one-time, or recurring outpatient, visit and is not assigned to a bed. For example, this event type may be used to signal the beginning of a visit to an Emergency Room.
A05	An A05 event is sent as a result of a patient undergoing the preadmission process.
A06	An A06 event indicates that a patient has changed from an outpatient status to an inpatient status.
A08	An A08 event indicates that patient information, such as demographics or contact information has been updated. No action is required from providers when this event populates.
A11	An 11 event indicates a cancelled admit or visit.
A13	An A13 event indicates a cancelled discharge/end visit.